Table 9. Alternative Therapies for Treatment of VMS

Agents	Comments	Refs.
Agents with inconsistent reports of benefit		
Genistein	Purified isoflavone ±Estrogenically active Breast safety not established	324–336
Daidzein	Purified isoflavone ±Estrogenically active Breast safety not established	324–336
S-equol	Metabolite of daidzein	337
Nonpurified isoflavones	Breast safety not established	338
Flaxseed		225, 236, 328, 339–341
Red clover	Breast safety not established	225, 236, 328, 339–341
High-dose extracted or synthesized phytoestrogen		225, 236, 328, 339–341
Dietary soy	Agreement about breast safety	248
Vitamin E	10% benefit in some studies	217, 342, 343
Reports with predominantly no benefit		
Black cohosh	Some short-term trials report benefit, most report no benefit Breast safety not established Reports of liver toxicity	225, 344–352
Omega-3 fatty acids	No benefit in MSFLASH trial	246
Acupuncture	Not effective when compared to "sham acupuncture" controls	353–356
Exercise	Exercise with sweating may increase hot flashes	357
Other complementary approaches	Ginseng, dong quai, wild yam, progesterone creams, traditional Chinese herbs, reflexology, magnetic devices	225, 332
Agents requiring further study		
Stellate ganglion block	Need further RCTs to establish lack of complications	358
Guided relaxation	Stress management, deep breathing, paced respiration, guided imagery, mindfulness training	217, 225, 247, 359–365
Hypnosis	Recent studies suggest efficacy	247
Cognitive behavior modification	Recent studies suggest efficacy with trained practitioners	366, 367

estrogenic properties. Caution is advised because some of these agents, when consumed as supplements, can exert estrogenic effects, a concern in breast cancer survivors although dietary soy appears to have no adverse effects on breast cancer prognosis (248).

5.0 Treatment of genitourinary syndrome of menopause

5.1 Vaginal moisturizers and lubricants

5.1a For postmenopausal women with symptoms of VVA, we suggest a trial of vaginal moisturizers to be used at least twice weekly. (2|⊕⊕◯◯)

Evidence

Vaginal moisturizers (eg, polycarbophil-based moisturizer, hyaluronic acid-based preparations, and a pectin-based preparation), when used regularly (at least twice weekly), may provide an effective nonhormonal approach to alleviating symptoms of vaginal atrophy. However, studies have been small, mostly open-labeled, and limited to 12 weeks (249–257). Although helpful, these approaches are not likely as effective as vaginal ET. Vaginal moisturizers have not been shown to reduce urinary tract symptoms or asymptomatic bacteriuria. Use of a vaginal moisturizer may not eliminate the need for a vaginal lubricant during intercourse.

5.1b For women who do not produce sufficient vaginal secretions for comfortable sexual activity, we suggest vaginal lubricants. (2|⊕⊕◯◯)

Evidence

Vaginal lubricants are used to enhance the sexual experience in women with symptoms of VVA by alleviating vaginal dryness and preventing dyspareunia (258). Lubricants do not treat the underlying problem and only briefly alleviate symptoms. Several OTC options are available. Because data do not demonstrate the superiority of one to another, women can experiment with these products. Olive oil is also effective (259). Petroleum jelly has been associated with an increased rate of bacterial vaginosis (260).

5.2 Vaginal estrogen therapies

5.2a For women without a history of hormone- (estrogen) dependent cancers who are seeking relief from symptoms of GSM (including VVA) that persist despite using